

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41368**  
**5072**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>	
c. LENGTH OF STAY (in this place) <b>5 yrs</b>		d. STREET ADDRESS (If rural, give location) <b>622 Harrison Street</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>GENERAL HOSPITAL #2</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>MARY</b>	b. (Middle)	c. (Last) <b>WILSON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>NOVEMBER 22 1949</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>OCTOBER 25 1910</b>	9. AGE (In years last birthday) <b>39</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 60 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAID</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>FORT SMITH, ARKANSAS</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
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13a. FATHER'S NAME <b>ALLEN DADE</b>	13b. MOTHER'S MAIDEN NAME <b>ALICE</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>LUCINDA DYER 622 Harrison Street</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>UNDETERMINED pulmonary congestion &amp; edema</b> <b>(PENDING FURTHER STUDY)</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>acute toxic degeneration, heart, liver, spleen, kidneys</b> DUE TO (c) <b>cause undetermined</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>442X</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 11-21, 1949, to 11-22, 1949, that I last saw the deceased alive on 11-22, 1949, and that death occurred at 4:50A m., from the causes and on the date stated above.

23a. SIGNATURE <b>E. Frank Ellis</b> (Degree or title)	23b. ADDRESS <b>600 East 22nd Street</b>	23c. DATE SIGNED <b>11-22-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>11-29-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Highland</b>	24d. LOCATION (City, town, or county) (State) <b>N.C. Mo.</b>
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DATE REC'D BY LOCAL REG. <b>11-29-49</b>	REGISTRAR'S SIGNATURE <b>Sheraldine Holmes</b>	FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Adkins Bros. Funeral Home</b>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Dr. Wright  
Gen. #2*

*2630*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed C. Kenneth Kerford

Licensed Embalmer No. 4437

P. O. Address \_\_\_\_\_

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.